

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Avir at Pecos		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 Memorial Drive Pecos, TX 79772	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 5 residents reviewed for care plans. (Resident #1, and #2)The facility failed to ensure Resident #1's care plan included fall precautions.The facility failed to ensure Resident #2's care plan included his medical diagnoses, conditions, and special diet order.This failure had the potential to affect residents by placing them at risk for unmet care needs. Findings included: Resident #1 Record review of Resident #1's admission Record dated 07/21/2026 revealed an [AGE] year-old male with admission date 04/22/2026. Record review of Resident #1's history and physical dated 04/21/2026 revealed a medical history of ambulation dysfunction (abnormal, uncoordinated or difficult walking pattern). Record review of Resident #1's Quarterly MDS dated [DATE], revealed a BIMS of 06, indicating the resident had severe cognitive impairment. Under Section J-Health Conditions, indicated Resident #1 had a recent fall since admission without any injury. Record review of Resident #1's Care Plan dated 04/23/2026, did not address fall interventions being implemented. In an observation of Resident #1's room on 07/21/2026 at 11:00am, revealed to have fall mat folded and placed against the wall. It was not in use as the resident was not in the room at that time. Resident #2 Record review of Resident #2's face-sheet dated 07/21/2026 revealed an [AGE] year-old male with admission date 05/22/2026. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Comprehensive MDS dated [DATE] revealed a BIMS of 11, indicating moderate cognitive impairment. Record review of Resident #2's history and physical dated 04/23/2026 revealed a medical history of: Chronic Kidney Disease (a long-term condition in which the kidneys gradually lose their ability to function properly); Gait disturbance (normal walking pattern is altered); and Hypertension (high blood pressure). Resident #2's diet order dated 04/23/2026 reflected Cardiac AHA diet (a heart-healthy eating pattern rich in fruits, vegetables, whole grains, plant-based proteins, and unsaturated fats while limiting sodium, added sugars, saturated fats, and ultra processed foods). Record review of Resident #2's care plan with date initiated 05/26/2026, and revision date 07/14/2026, revealed the care plan did not include or address Resident #2's medical diagnoses, or his special diet. In an interview on 07/21/2026 at 5:11pm with LVN A, she stated any fall precautions that were being implemented such as low bed, call light within reach and fall mat needed to be included in the care plan. She stated that a resident's diagnosis should have been included in the care plan as well. She stated that it was important for fall precautions to be included so that the staff knew about the fall preventions that were being implemented. She stated that health information needed to be included in the care plan as well to monitor the progression of their health conditions and to establish a baseline. She stated that a risk of not including fall preventions and health conditions would be the staff not knowing what precautions to take with the residents and more of the same incidents such as falling could continue to happen. She stated that the care plan was updated every three months by the MDS nurse. She stated that the MDS nurse recently quit and that the facility did not have an MDS nurse onsite at the moment. She stated that she believed that there was a corporate MDS nurse covering while the facility hired another MDS nurse. In an interview on 07/21/2026 at 5:41pm with the DON she stated that any falls and fall preventions should be updated in the care plan. She stated that health conditions were to also be included in the care plan so that all staff were aware of the Residents' entire health conditions and implementations of fall precautions to avoid further incidents. She stated that there was a nurse that was helping with MDS but she left in June 2026 before she could teach the nurses how to complete a careplan. She stated that it was the responsibility of the MDS nurse to update the care plans but since she left it became the responsibility of herself, and the ADONs. She stated she was checking them weekly, but she stopped doing that because there was a lot going on. She stated that the corporate MDS nurse was responsible for overseeing them and ensuring that care plans were being updated as needed. In an interview on 07/21/2026 at 6:20pm with the corporate MDS nurse, He stated that the purpose of the care plan was to set forth goals for patient care. It should have included MDS triggers. It also includes interventions to keep the Residents safe. He stated that falls, fall precautions, and health conditions were to be included in the care plan. He stated that nursing was responsible for creating the baseline care plan in 48 hours within admission and monitored at least quarterly. He stated that the remote MDS nurse was responsible for updating care plans daily, and he was responsible for overseeing the remote MDS nurse weekly. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/21/2026 at 7:05pm with the Administrator he stated that falls, fall precautions and health conditions were to be included in the care plan so that all the staff was aware of the interventions that were in place for the Residents. He stated that he, the DON and the MDS nurse were all responsible for ensuring that the care plans were being updated and completed correctly. He stated that the corporate MDS nurse oversees them weekly. He stated that the risk was care not being properly delivered to the resident if not all staff were aware of the health conditions or fall precautions to be used. Review of the Nursing Facility's Care Plans, Comprehensive Person-Centered policy, dated with revision date 03/2022, read in part, under Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and implemented for each resident. Under Policy Interpretation and Implementation, read in part: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within 7 days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. It continued to read in part: 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASSAR recommendations; and (3) which professional services are responsible for each element of care. C. includes the resident's stated goals upon admission and desired outcomes.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interviews and records review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to take actions aimed at performance improvement and after implementing those actions, measure its success, and track performance to ensure that improvements were realized and sustained.-The facility failed to monitor and track performance of the black debris presence in the 300-hall shower room.The failure could place residents within the facility at risk for potential illness.An observation was made on 07/21/2026 at 3:05 PM in the 300-hall shower room of the inner bottom corners of the shower with white paste that was open with black debris underneath.Record review of the Nursing Facility's Quality Assessment and Performance Improvement Plan 2026, dated 06/2026, read in part under Environmental Rounds: Monitored by Administrator/Maintenance. No additional comments regarding or addressing the environment or the shower rooms were noted.In a phone interview on 07/21/2026 at 4:45 PM with the Maintenance Supervisor, he stated he was aware of the black debris in the 300-hall shower room. The Maintenance Supervisor stated the Nursing Facility had cleaned the observed black particles on 300-hall shower's inner floor corners, which was done with a chemical and a wire brush. The Maintenance Supervisor stated he had removed the black particles from the 300-hall shower floor corners and applied Caulking (a waterproof filler or sealant used for buildings or repair) and was not aware of any black particles in the shower room until today 07/21/2026. The Maintenance Supervisor stated he was unable to recall the date the black particles were removed and stated he did not have invoices or receipts relating to the shower room. The Maintenance Supervisor stated he had conducted weekly rounds and did not have any concerns. He stated he did not document his rounds or their findings, including anything relating to the 300-hall shower room. The Maintenance Supervisor stated it was an expectation that he had documented identified concerns within the Nursing Facility and their resolution including any repairs made. He stated documentation and receipts would reflect the Nursing Facility's attempts to resolve identified concerns including the black debris observed in the 300-hall shower. The Maintenance Supervisor stated the identified concern of the black debris in the 300-hall shower was discussed during the supervisors daily rounding of the environment.In an interview on 07/21/2026 at 7:10 PM with the Administrator, he stated the Maintenance Supervisor and himself, as the Administrator, would round the Nursing Facility weekly to conduct environment checks including the 300-hall shower. The Administrator stated this was a part of their QAPI plan after the 300-hall shower was identified with black debris during their recent annual survey, exit 05/21/2026. The Administrator stated he did not document his weekly rounding and did not have any documentation reflecting monitoring of the shower during their rounds. The Administrator stated Maintenance would be responsible for documenting the monitoring and findings of the 300-hall shower room since he was responsible for reporting it to their regional office. The Administrator stated the purpose of documenting their rounding and findings of identified concerns included the Nursing Facility's monitoring rounds when completed and any findings. The Administrator stated he was not aware of any complaints of black particles observed in the 300-hall shower room until this day, 07/21/2026, and stated it had been believed to be resolved by the Maintenance Supervisor. Record review of the Nursing Facility's Plan of Correction, corrected 06/12/2026, included; the Administrator would monitor weekly that the . maintenance services maintain a sanitary, orderly and comfortable environment. The bathroom in 300 halls now is clean and free from black particles on the floor and shower room.Record review of the Nursing Facility's Quality Assurance and Performance (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Improvement (QAPI) Program, with revision date 02/2020, under Policy statement, read: This Facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Under Policy Interpretation and Implementation, it read in part: The objectives of the QAPI program are to: 1. provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Under Implementation, it read in part: 1. The QAPI committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI committee. 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. tracking and measuring performance; b. establishing goals and thresholds for performance measurement; c. identifying and prioritizing quality deficiencies; d. systematically analyzing underlying causes of systemic quality deficiencies; e. developing and implementing corrective action or performance improvement activities; and f. monitoring or evaluating the effectiveness of corrective action/performance improvements activities, and revising as needed. 3. The committee meets monthly to review reports, evaluate data and monitor QAPI-related activities to make adjustments to the plan.		